STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF PUBLIC HEALTH SERVICES

Nicholas A. Toumpas
Commissioner

José Thier Montero
Director

29 HAZEN DRIVE, CONCORD, NH 03301-6504
603-271-4741 1-800-852-3345 Ext. 4741
Fax: 603-271-4506 TDD Access: 1-800-735-2964

NEW HAMPSHIRE STATE LOAN REPAYMENT PROGRAM APPLICATION FOR HEALTH CARE PROVIDERS (Renewal Extension)

Please type or print and answer all questions:

Name: _____
Last First Middle

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ E-mail: _____

U.S. Citizen or U.S. National? ☐ YES ☐ NO DOB: _____

Please check your discipline and provide specialty if needed:

Discipline: ☐ MD ☐ PA ☐ CNM ☐ PNS ☐ MHC ☐ LPC

☐ DO ☐ DH ☐ CP ☐ CNP ☐ CSW ☐ MFT

☐ DDS ☐ DMD

Specialty: _____

Hours work per week: _____
Hours per week administrative duties:_____
How many days do you work per week? _____

Are you NH Board Certified? ☐ YES ☐ NO If No, When do you plan to receive? _____

Name of School(s), date and degree awarded:

_____

_____

How long employed at current facility? Years____ Months____
Date Employment Began or Will Begin: _____ Salary/Wage: _____

Employer Name: _____ Practice Name: _____

Primary Practice Site: _____

Days/week: _____ Hours/week: _____

Practice Address: _____

Town: _____ State: _____ Zip: _____ County: _____

Work Phone: _____ Fax #: _____

Secondary Practice Sites:

1. Town: _____ Days/week: _____ Hours/week: _____
2. Town: _____ Days/week: _____ Hours/week: _____

Is there a sliding fee scale, including free care? ☐ YES ☐ NO Posted in waiting Room ☐ Yes ☐ No

Is there any limit on the number of patients seen with Medicare/Medicaid? ☐ YES ☐ NO
If Yes, Explain _____

Is there any limit on the number of patients seen that are uninsured? ☐ YES ☐ NO
If Yes, Explain _____

Do you work 40 hours per week, no less than 4 days per week in a patient care practice, of which a minimum of 32 hours per week must be spent in direct patient care (for physicians the practice will include ambulatory care, as well as hospital care appropriate to meet the needs of patients and to assure continuity of care)? ☐ YES ☐ NO
If No, Explain how many hours per week and workweek schedule: _____
_____

Do you or your employer provide prenatal and delivery services? ☐ YES ☐ NO

Do you have any outstanding contractual obligations for health services to the:

Active Military: ☐ YES ☐ NO National Guard ☐ Yes ☐ No
National Health Service Corps Loan Repayment Program (NHSC LRP): ☐ YES ☐ NO
NHSC Scholarship Program: ☐ YES ☐ NO
Nurse Education Loan Repayment Program (NELRP): ☐ YES ☐ NO
Nursing Scholarship Program: ☐ YES ☐ NO
State or Other Entity: ☐ YES ☐ NO

If yes, when will the service obligation be completely satisfied? _____
Contact Information: _____

If you answered yes to any of these questions below, attach an explanation to the application.

Do you have a judgment lien against your property for a debt to the United States? ☐ YES ☐ NO

Do you have any federal debt written off as not collectible or any federal service or payment obligation waived? ☐ YES ☐ NO

Has your medical/certification license ever been suspended or revoked? ☐ YES ☐ NO

Are any professional disciplinary actions pending? ☐ YES ☐ NO

Have you ever been convicted or plead guilty to a felon as so defined under either Federal or State laws? ☐ YES ☐ NO

LOAN EXPENSES FOR MEDICAL PROFESSIONAL EDUCATION:

Lender Name/Address/Telephone #	Account #	Original Amt of Loan	Current Balance Due

***Attach other required documents as outlined on the next page.**

CERTIFICATION: (Notary Required)

I certify that the information given in this application and attachments is accurate and complete to the best of my knowledge. I understand that the information I have provided is subject to verification and that willfully providing false information may result in disqualification from participation in this program.

Signature: _____ Date: _____

Witness: _____ Date: _____
Notary Public or Justice of the Peace

Seal:

New Hampshire State Loan Repayment Program (SLRP)

Required supporting documents for State Loan Repayment Renewal Contract Applications

1. Provide a copy of your current NH Board Certified License/Certification to practice in New Hampshire (must show expiration date).
2. Attach evidence of your undergraduate or graduate medical or nursing educational loan balance(s).
3. Attach Completed Employer Information Sheet and all required attachments.
4. Provide updated resume reflecting current mailing address and current employer and your current title.

Note: It will be the responsibility of the applicant and/or the facility/community to seek out these matching funds before other renewal contracts are considered.

Please return completed application to**:**

NH DHHS, DPHS, Rural Health & Primary Care Section
ATTN: David Roberts, Primary Care Workforce Coordinator
29 Hazen Drive
Concord, NH 03301-6504

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New Hampshire State Loan Repayment Program (SLRP)
(Employer Questionnaire)

Please print or type and respond to all questions.

Applicant Information

Name of Loan Repayment Applicant: _____

Profession/Specialty: _____

1) Does the applicant have a current contract/employment agreement with your organization? ☐ YES ☐ NO
If yes, Start date of Applicant: _____ Expiration Date: _____

2) Do you anticipate renewing the contract/employment agreement when it expires? ☐ YES ☐ NO
If no, please explain: _____

3) Is this applicant's employment contingent on obtaining a renewal loan repayment? ☐ YES ☐ NO
If yes, please explain: _____

4) Does this healthcare provider have a current and unrestricted New Hampshire Medical License/Certification to practice in New Hampshire? ☐ YES ☐ NO
If no, please explain: _____

5) This applicant is applying for a? Please check one.
☐ 2yr extension contract (FT)
☐ 1yr extension contract (P/T)

Employer Information:

Name of Employer Organization: _____

Contact Person: _____ Title: _____

Phone: _____ Fax: _____ E-Mail: _____

Street Address: _____

City: _____ State: _____ Zip: _____ County_____

1) Practice Information, please check one: ☐ Fed. Qualified Health Center (FQHC) ☐ DPHS Funded Clinical Health Ctr. ☐ Rural Health Clinic ☐ Critical Access Hospital ☐ Rural Referral Ctr. ☐ Dental Clinic ☐ Public, Not For Profit ☐ Private, For Profit ☐ Other_____

2) Describe your payor mix in the last 6 months and describe your bad debt/charity care as % of revenue for the last 6 months.

3) Does your healthcare facility have a sliding fee schedule in place, including free care? ☐ YES ☐ NO Is it posted in the waiting room? ☐ Yes ☐ No

4) Do you accept all patients regardless of method of payment, including Medicaid, Medicare assignment and ability to pay? ☐ Yes ☐ No

5) Priority is given to renewal applications that include a 50% facility or community non-federal match. If this applicant is awarded state loan repayment, has your organization and/or community budgeted funds to match 50% of the award each year for the contract? ☐ Yes ☐ No
If full matching funds are not available, a letter describing any extenuating circumstances or hardship must be attached in order for this application to be considered for funding.

6) If unable to provide 50% of the matching funds, is there a percentage or dollar amount that your organization or community is willing to provide towards the applicant's renewal contract? ☐ YES ☐ NO;
Explain the Percentage or Amount that the organization or community is willing to provide toward the contract: $_____.

Print Contact Name: _____
Facility's Authorized Representative

Signature: _____
Facility's Authorized Representative

Title: _____ Date: _____

If you have any questions, please call, 603-271-2276, Fax 271-4506 or E-Mail: droberts@dhhs.state.nh.us
To learn more about the State Loan Repayment Program you may go to our web site at:
http://www.dhhs.nh.gov/DHHS/RHPC/default.htm

Mailing Address:
NH DHHS, DPHS, Rural Health & Primary Care Section
ATTN: David Roberts, Primary Care Workforce Coordinator
29 Hazen Drive
Concord, NH 03301-6504